living wellness centre

Patient Intake Form

By filling out this comprehensive intake form, you are helping us to provide you with more effective care. We thank you for your time and patience in doing this.

PATIENT INFORMATION Date

Full Name I go by

Care Card Number (PHN)

Birthday (mm/dd/yy) Age ☐ Male ☐ Female

Home Address

City Postal Code

Primary Telephone Cellphone

Email

Would you like an email reminder for your appointments? ☐ Yes ☐ No

Occupation Work Telephone

May doctor and/or staff contact you at work? ☐ Yes ☐ No

Name of General Practitioner (MD) Telephone

Name of emergency contact

Relation to you Telephone

Where did you hear about Living Wellness Centre?

Office use only MSP ☐ Yes ☐ No ☐ CND ☐ Jane ☐ W/C ☐ GS

living wellness centre

Health History

NAME Date

HEALTH ISSUES

Main Concern

Other Concern(s)

Have you ever been treated by any of the following: ☐ Acupuncturist ☐ Massage Therapist ☐ Chiropractor ☐ Naturopath

Is your condition part of an ICBC or WCB claim? ☐ Yes ☐ No (If yes, please ask for additional forms.)

MEDICATIONS Please list any medications/supplements you are taking and doses.

Medications (prescription, over the counter)

Supplements (multivitamins, gingko, etc.)

LIFESTYLE

Overall stress level ☐ none ☐ low ☐ medium ☐ high

How often do you exercise? Type of exercise

Do you currently smoke? ☐ Yes ☐ No

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No ☐ Maybe if yes, due date

Do you have children? ☐ Yes ☐ No If yes, by ☐ vaginal birth ☐ caesarean birth

Menstrual cycle ☐ regular ☐ irregular ☐ painful cycle

Date of your last annual Pap/Breast exam

living wellness centre

Additional Health History

NAME Date

IMMUNIZATIONS

Did you receive general childhood vaccinations? ☐ Yes ☐ No

Check any other vaccines taken: ☐ Hepatitis A ☐ Hepatitis B ☐ Flu shot ☐ Others

ALLERGIES

Please list any allergies or sensitivities in the following categories.

Medications

Foods

Environmental/chemical

MEDICATIONS

Please check if you use any of the following.

☐ Alcohol ☐ Antacids ☐ Anti-inflammatories ☐ Caffeine ☐ Cortisone ☐ Laxatives
☐ Marijuana ☐ Pain relievers ☐ Sleeping pills ☐ Tranquilizers ☐ Other drugs

Were you ever on antibiotics for more than 1 month over the last 10 years? ☐ Yes ☐ No

Have you ever used probiotics (acidophilus) following antibiotic use? ☐ Yes ☐ No

FAMILY HISTORY

Please check if you have a family history of any of the following:

☐ Arthritis ☐ Asthma/allergies ☐ Cancer ☐ Depression ☐ Diabetes ☐ Drug/alcohol abuse
☐ Epilepsy ☐ High blood pressure ☐ High cholesterol ☐ Kidney disease ☐ Mental Illness ☐ Stroke
☐ I don't know my family history ☐ Other

SLEEP

Time you go to sleep Time you wake up

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you wake well rested in the morning? ☐ Yes ☐ No

DIET

Do you follow any particular diet regimens or restrictions? ☐ Yes ☐ No

If yes, please specify:

living wellness centre

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan
___ Irritability / frustration / impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / dry / itchy eyes
___ Headaches / migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / Sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
___ Frequent urination
___ Bladder infection
___ Lack of bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei
___ Dry cough
___ Cough with phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Prefer warm / cold drinks
___ Sweat easily

List your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what you crave. (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Do you wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

living wellness centre

Acupuncture Declaration & Consent to Treatment

Please read the following carefully and enquire if you have any questions or concerns.

Traditional Chinese medicine, acupuncture and other treatments provided by this clinic have been proven to be highly effective and very safe. However, we are required to inform patients that there may be some risks involved and that practitioners cannot anticipate all possible complications. The following are some of the side effects that can occur.

- Drowsiness following treatment. If this occurs, you are strongly advised not to drive following treatment
- Minor bleeding or bruising can be caused by acupuncture.
- Irritation of the skin due to allergies if a topical lotion or oil is used. You should inform us if you are nervous of needles or have a history of fainting for any reason.
- Worsening of symptoms. In a small percentage of patients, symptoms can become worse before improving. This is generally a sign that healing has begun. If the worsening of symptoms is severe or lasts more that two days, we urge you to contact us.

The following rare but serious problems have been reported in literature. Precautions are always observed to avoid such complications.

- Joint infection: This can occur if bacteria on the skin are introduced to a joint by the needle. Some acupuncture points go into the joint and can therefore introduce infection. This is very rare and has never been experienced by our practitioners.
- Nerve damage: Some acupuncture points are over nerves, and there is therefore the theoretical possibility of nerve damage. This is very rare and has never been experienced by our practitioners.
- Pneumothorax (collapsed lung): If the needle is inserted too deeply between the ribs or above the lungs, it may pierce a lung and cause a Pneumothorax. This is very rare and has never been experienced by our practitioners.
- Needle breakage: If a needle were to break during insertion, it may require surgical removal. Again, this is very rare and has never been experienced by out practitioners.

The use of sterilized, disposable needles at this clinic eliminates the risk of hepatitis B, hepatitis C, and AIDS/HIV transmission. Our needles are used once and safely disposed of.

It is important that you inform us if any of the following apply to you:

- If you are pregnant;
- If you have a pacemaker or other electrical implant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have any allergies;
- If you have ever felt faint of had any unusual or negative sensation from acupuncture or medical treatments;
- If you are at higher risk of infection.
- If you have high or low blood pressure.

Signature Date

Full Name

Practitioner Signature